The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619

December 11, 2000

Dear Colleague:

Last December we wrote to you about emergency department diversion of ambulances and provided to you some Best Practice Guidelines for consideration in dealing with the problem. We know that hospitals used the Guidelines to address the diversion issue both in their own institution, as well as in coordinating with other pre-hospital and hospital providers. We appreciate those efforts.

However, the problem continues and our concerns have been heightened. It is apparent that diversion is no longer a seasonal event. In some areas of the state, diversions this past summer were as frequent as the winter of 1999. We feel that further measures may need to be instituted immediately in anticipation of this winter's influenza season.

In response to our heightened concern about ambulance diversions, the Department of Public Health and the Massachusetts Hospital Association are providing in the attached document further recommendations on measures that hospitals can and should take to both prevent going on diversion and to manage the process more effectively when diversion becomes necessary. These recommended measures build on the Best Practice Guidelines developed earlier.

Please contact either Brad Prenney at the Department of Public Health (617) 284-8401 or Leslie Kirle at the Massachusetts Hospital Association (781) 272-8000 should you have any questions, concerns, or recommendations.

Sincerely,

Howard Koh MPH

Howard K. Koh, M.D., MPH
Commissioner
Massachusetts Department of Public Health

Ronald Hollander
President
Massachusetts Hospital Association

MEASURES THAT HOSPITALS SHOULD TAKE REGARDING AMBULANCE DIVERSIONS

(A) Intra-Institutional Measures: What a hospital should do internally (prevention and planning measures)

- Hospitals should ensure that plans are in place to address community disasters/emergencies, and, that existing plans address the emergency preparedness associated with peak periods of demand. These plans should address measures to take to prevent going on diversion and to minimize and manage diversion when it becomes necessary (see Best Practice Guidelines).

- Where appropriate, institute procedures to get non-emergent patients out of the emergency department and into other treatment areas such as outpatient departments and satellite treatment facilities.

- Establish the staffing of all licensed beds as a priority goal during periods of peak demand.

- For periods of overcrowding, hospitals should have a plan governing admission practices. The plan should:

  - based upon consideration of patient safety and need, give priority for admission to emergency cases from the community and from the hospital's emergency department.
  - include policies around the scheduling of elective surgeries that maximize the capacity to meet the variable demand for inpatient beds generated by patients entering through the emergency department.
  - distinguish between elective surgical care that can be safely postponed and those surgical cases that are urgent in nature.

- Consider rescheduling truly elective surgeries when inpatient beds are needed by higher acuity patients from the emergency department or community.

- Institute procedures that allow for timely and efficient discharge of inpatients to home or appropriate post-acute care facilities.

- Contact the Department when questions arise as to the possibility of increasing staffed bed resources through the temporary use of transitional care units or of previously de-licensed beds.

- Minimize the time that patients remain in the emergency department after the decision has been made to admit or transfer. Ensure, for those patients that are admitted but are awaiting a bed, that care is coordinated with the service to which the patient has been admitted.

- **Assure appropriate transfer of patients who have been assessed, stabilized and who need inpatient services when an inpatient bed will not soon be available.**

- **Consider hiring and/or cross training appropriate staff to expand staffed bed capacity and utilization to meet increased demand.**

- Provide flu clinics for staff and prehospital providers and prioritize vaccination to care providers at greatest risk of exposure.

(B) Inter-Institutional Measures: What a hospital should do through cooperative arrangements with other hospitals and prehospital providers

- **Develop coordinated diversion policies with ambulance services, Regional EMS Councils and other hospitals in your service area. These policies should focus on reaching agreement around:**

  - common definitions and terms (e.g. boarding, saturation, diversion, etc.).
  - measures to be taken prior to requesting diversion of ambulances.
  - measures to minimize the time on diversion.
  - circumstances when a hospital must go off diversion.

- Ensure expeditious transfer of patients from EMS to hospital staff so as to facilitate getting ambulances back in service.

- Cooperate with other service area providers to develop and institute notification systems that allow for real-time notification of hospital(s) diversion status.

- Reduce demand for emergency department resources by working cooperatively with health care providers to direct patients with lower acuity to other facilities (e.g. urgent care clinics) that can provide timely and appropriate care.

- **Establish agreements and arrangements with other hospitals that facilitate appropriate transfer of patients when the hospital nears saturation.**

BEST PRACTICE GUIDELINES FOR HOSPITALS REGARDING AMBULANCE DIVERSIONS

BACKGROUND AND STATEMENT OF PURPOSE

In 1988, the Massachusetts Hospital Association (MHA) published a report and recommendations of a task force convened in response to a dramatic increase in the frequency with which hospitals diverted incoming ambulance traffic from their emergency departments. The report, "Patient Overload and Ambulance Diversion," focused on three key areas: (1) internal hospital operating procedures and policies; (2) inter-hospital communications and (3) communications between hospitals, pre-hospital providers and the public.

The guidance provided in the 1988 report produced a number of improvements; most hospitals now have diversion policies in place, including policies to triage and to manage bed capacity; and communications between hospitals and pre-hospital providers have improved largely through the coordinated efforts between hospitals and Regional EMS Councils.

Despite the efforts expended over this past decade, many of the factors that contributed to the problem a decade ago continue to affect hospitals and pre-hospital providers today. In addition, many hospitals have closed and others have reduced staffing and beds, further reducing capacity within the system. The seasonal spike in utilization typically experienced by hospitals in winter months was more extreme the last two years, resulting in ambulance diversions increasing significantly in both frequency and duration. Variation in patterns of seasonal use also have become more volatile. While the utilization pattern was similar statewide not all hospitals shared the same experience. Occupancy rates were also higher during the winter of 1998 and 1999; averaging 75 percent of staffed beds and 79 percent of staffed beds when observation is included. Nearly all the increase was attributable to respiratory illnesses, including the flu, among the very old and very young.

Well over half of our hospitals, statewide, have had to go on diversion at one time or another this year. In one region of the state, virtually every hospital has been on diversion in 1999. That region has experienced a 46% increase in the frequency of diversions so far this year as compared to last year and has seen the total time the region's hospitals are on divert increase 63 percent.

Early in 1999, Howard K. Koh, MD, MPH, Commissioner of the Massachusetts Department of Public Health, in conjunction with the Massachusetts Hospital Association, convened a task force to study the current causes of ambulance diversions and to investigate immediate and long-term solutions to the problem. The task force included representation from the Massachusetts Medical Society, the Massachusetts College of Emergency Physicians, the Massachusetts Organization of Nurse Executives and the Regional EMS Councils among others.

The Commissioner's charge to the task force was to develop best practice guidelines for hospitals to use both to minimize the need to go on diversion and to ensure that the system responded in a coordinated and efficient manner when diversion became necessary. Like its predecessor a decade ago, the current ambulance diversion task force recognizes that ambulance diversions are less often a result of a sudden increase in ED census than a response to too few staffed beds elsewhere in the hospital, most commonly in critical care and/or intensive care units.

The accompanying document offers a comprehensive range of best practice principles that hospitals can consider adopting internally and which are meant to promote greater coordination among hospital and pre-hospital providers. These Best Practice Guidelines have drawn heavily from the experience and wisdom of the 1988 MHA Report and the recommendations of the previous Task Force.

BEST PRACTICE GUIDELINES FOR HOSPITALS REGARDING AMBULANCE DIVERSIONS

(A) Intra-Institutional Best Practices: What a hospital needs to do internally (prevention and planning activities)

Develop policies that address the causes for diversion and implement practices that minimize the need for diversion. These policies might include such elements as maximizing bed capacity and other steps internal to each hospital to maximize internal communication. Effective diversion policies may include consideration of triage or rescheduling of elective admissions and/or treat and transfer protocols.

- Maintain a daily bed management and tracking system to facilitate the flow of patients admitted and discharged. This system should allow the identification of the following:

  - Projected discharges
  - Scheduled admissions
  - Transfers out of ICUs to routine beds
  - Projected emergency admissions
  - Available beds by service, including critical care

- Develop diversion criteria and any relevant exceptions within the institution based on institution-specific needs and an analysis of the availability of external resources (e.g., other hospital emergency departments and in-patient services within the service area of the hospital).

- Determine who specifically makes the decisions to initiate a full or partial diversion and the process used for making the decision to divert, including internal and external communication channels. In developing communication channels consider:

  - Other hospitals in service area
  - Regional EMS/Pre-hospital providers
  - Municipal agencies (fire, police, health)
  - Press/Media

- In order to maximize bed utilization, notify the appropriate hospital staff as soon as it has been determined that a potential overload of patients might occur. In addition to notifying key personnel, it is essential to alert physicians of the high census and potential shortage of beds.

(B) **Inter-Institutional/Service Best Practices: Meet and communicate with other hospitals and pre-hospital transport services BEFORE there is a need for diversion**

- Once the plan has been developed internally, meet with other service area providers and pre-hospital transport services to discuss and refine your own plan, and come to a common understanding of what will happen in the event of a diversion

- Develop coordinated policies (agreements) with other hospitals in the same service area to include:

  - Communications
  - How to manage emergency transports when all are on diversion

- Develop coordinated policies (agreements) with Regional EMS and EMS providers

  - Defining by agreement how EMS providers shall proceed when there is a diversion
  - Defining by agreement exceptions to diversion
  - Defining by agreement who makes the decision to override the diversion decision
  - Defining by agreement the coordination of inter-facility transfers, in-patient bed capability with surrounding and network affiliated hospitals

(C) **Communication and Coordination Best Practices: What actually happens once a diversion decision has been made**

- Communicate diversion decision to other stakeholders

  - Notification of EMS system
  - Notification of other hospitals

- Manage diversion while diversion status is on-going

- Maintain ongoing communication with C-MED system

- Continue to monitor bed and ED capacity and notify C-MED system of any changes in diversion status

- Maintain and monitor data on frequency, duration, and reasons for diversion

- Coordinate media interactions with MHA and DPH